DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 98-004

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 1998

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 98 $ (9,154)
b. FFY 99 $ 14, 979

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A pages 2, 3, 4, 5, 6, 10b, 11, 12 18, 19, and 20

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A pages 2, 3, 4, 5, 6, 10b, 11 12, 18, 19, and 20, 10d and 23

10. SUBJECT OF AMENDMENT: Rebase hospital cost per diem rates to 1995 cost reports and applied full trend factors and establish the add-on payments forunreimbursed Medicaid costs and the costs of the uninsured for state fiscal year 1998 (July 1, 1997 to June 30, 1998) based on 1995 cost reports.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director

15. DATE SUBMITTED:
6/29/98

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
06/30/98

18. DATE APPROVED:
AUG 28 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPRCVED MATERIAL:
04/01/98

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Fsoter Reilly

22. TITLE:
Acting ARA for Medicaid & State Operations

23. REMARKS:
Martin
Wagner
Kaye
(MRM/CO)

SPA CONTROL
Date Submitted 06/29/98
Date Received 06/30/98

FORM HCFA-179 (07-92)

Instructions on Back

3. Disproportionate share reimbursement - The disproportionate share payments described in sections XVI and XVIII include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection VI.A.1 and 2 and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation are described in sections XVI, and XVII. These Safety Net and Medicaid Add-Ons are subject to federal limitation described in Omnibus Reconciliation Act of 1993 (OBRA 93) and section VI.E.

II. Definitions.

A. Allowable costs. Allowable costs are those related to covered Medicaid services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the Missouri Medicaid hospital provider manual and detailed on the desk reviewed Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item.

B. Bad debt - Bad debts should include the costs of caring for patients who have insurance but are not cover the particular services, procedures or treatment rendered. Bad debts should not include the cost of caring for patients whose insurance covers the given procedures buts limits coverage. In addition, bad debts should not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

C. Base cost report--Desk-reviewed Medicare/Medicaid cost report for the latest hospital fiscal year ending during the calendar year. (For example, a provider has a cost report for the nine (9) months ending 9/30/94 and a cost report for the three (3) months ending 12/31/94.) If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.

D. Charity Care - results from a providers policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

E. Contractual allowances--Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

F. Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report.

G. Disproportionate Share Reimbursement. The disproportionate share payments described in sections XVI and XVIII include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection V.A.1 and 2 and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation are described in sections XV, XVI, and XVII of this regulation. These Safety Net and Medicaid Add-Ons are subject to federal limitation as described in the Omnibus Reconciliation Act of 1993 (OBRA 93) and subsection VI.E.

H. Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification of the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

I. Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR part 405) as determined by the servicing fiscal intermediary based on yearly Hospital Cost Reports.

J. Nonreimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;

2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;

3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and

4. Costs or services or costs and services specifically excluded or restricted in this plan or the Medicaid hospital provider manual.

K. Per Diem rates. The per diem rates shall be determined from the individual hospital cost report in accordance with section III.

L. Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's Medicaid per-diem cost per day as determined in accordance with the general plan rate calculation from section III of this regulation using the base year cost report (by dividing allowable Medicaid inpatient costs by total Medicaid inpatient days, including nursery days).

M. Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

N. Children's hospital. An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) and which has designed in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit as defined in 19 CSR 30-20.021(4)(F).

O. Hospital-sponsored primary care clinic--A clinic location which has met all of the following criteria:

1. The clinic shall not be physically located within a licensed hospital;

2. The clinic must be enrolled as a Medicaid provider;

3. The clinic is not certified by the Division of Health Standards and Quality, Health Care Financing Administration (HSQ/HCF) as being part of any hospital; and

4. The sponsoring hospital has completed and returned the Hospital-Sponsored Primary Care Clinic Application to the Missouri Division of Medical Services by May 1, 1994, providing verification of the following:

A. The sponsoring hospital and the clinic are subject to the bylaws and operating decisions of the same governing body; or

B. The sponsoring hospital contributes at least five hundred thousand dollars ($500,000) annually towards the operation of the clinic.

III. Per-Diem Reimbursement Rate Computation. Each hospital shall receive a Medicaid per-diem rate based on this computation.

A. The per diem rate shall be determined from the 1995 base year cost report in accordance with the following formula:

$$\text{PER DIEM} = \frac{(OC * TI)}{MPD} + \frac{CMC}{MPDC}$$

1. OC-The operating component is the hospital's TAC less CMC;

2. CMC The capital and medical education component of the hospital's TAC;

3. MPD-Medicaid inpatient days;

4. MPDC-MPD as defined in III.A.3. with a minimum utilization of sixty percent (60%) as described in paragraph V.C.4.;

5. TI-Trend Indices. The trend indices are applied to the OC of the per-diem rate. The trend indices for SFY 95 is used to adjust the OC to a common fiscal year end of June 30;

6. TAC-Allowable inpatient routine and special care unit expenses, ancillary expenses and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The per diem shall not exceed the average Medicaid inpatient charge per diem as determined from the base year cost report and adjusted by the TI.

8. The per diem shall be adjusted for rate increases granted in accordance with subsection V.F., for allowable costs not included in the base year cost report

B. Trend Indices (TI). Trend indices are determined based on the four (4) quarter average DRI Index for DRI-Type Hospital Market Basket as published in Health Care Costs by DRI/McGraw-Hill.

1. The TI are-

A. State Fiscal Year 1994-4.6%.,
B. State Fiscal Year 1995-4.45%;
C. State Fiscal Year 1996-4.575%;
D. State Fiscal Year 1997-4.05%;
E. State Fiscal Year 1998-3.1%;

2. The TI for SFY 96 through SFY 98 are applied as a full percentage to the OC of the per-diem rate.

3. Effective date. This per diem rate shall be effective for services delivered on and after April 1, 1998.

IV. Per-diem Rate New Hospitals.

A. Facilities Reimbursed by Medicare on a Per-Diem basis. In the absence of adequate cost data, a new facility's Medicaid rate may be its most current Medicare rate on file for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

B. Facilities Reimbursed by Medicare on a DRG Basis. In the absence of adequate cost data, a new facility's Medicaid rate may be one hundred twenty percent (120%) of the average-weighted, statewide per-diem rate for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for the third fiscal year will be the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

V. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon request of the hospital and the approval of the Missouri Division of Medical Services when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and post marked prior to the first day of the sixth (6th) month following the hospital's fiscal year end.

VI. Disproportionate Share

A. Impatient hospital providers may qualify as a disproportionate share hospital based on the following criteria. Hospitals shall qualify as disproportionate share hospitals for a period of only one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue their disproportionate share classification.

1. If the facility offered non-emergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to those services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a Metropolitan Statistical Area, as defined by the federal executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer non-emergency obstetric services as of December 21, 1987;

2. As determined from the third prior year desk reviewed cost report, the facility must have either--

(a) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean Medicaid inpatient utilization rate for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded.

$$\text{MIUR} = \frac{\text{TMD}}{\text{TNID}}$$

or;

(b) A low income utilization rate in excess of twenty-five percent (25%).

(1) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

4. As determined from the third prior year desk reviewed cost report, the hospital:

   (a) Has an unsponsored care ratio of at least sixty-five percent (65%); or

   (b) The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo and the Missouri Rehabilitation Center created by Chapter 199, RSMo or their successors.

   (c) The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

5. As determined from the third prior year desk reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.

B. Those hospitals which meet the criteria established in paragraphs (VI)(A)., 2. and 4. shall be deemed first tier ten percent (10%) Add-on disproportionate share hospital a (DSH) and will receive DSH payments in accordance with Section XVI on page 17. Those hospitals which meet the criteria established in (VI)(A)1. and 3., or paragraphs (VI)(A)1. and 2. shall be deemed a DSH hospital and receive DSH payments in accordance with Section XVII on pages 18 to 20.

C. As hospital not meeting the requirements in subsection VI.A., but has a Medicaid inpatient utilization percentage of at least one percent (1%) for Medicaid eligible recipients may at the option of the state be deemed a Disproportionate Share Hospital (DSH) provided the hospital meets the requirements in Section VI.A.1., of page 10b. These facilities may receive only the DSH payments identified in Section XVII.

Substitute per letter dated 6/12/01

D. Hospitals shall not send amended cost reports or other data necessary for qualification for disproportionate share classification for purposes of rate reconsideration unless the reports or other necessary data are received within sixty (60) days of the date of the division's notification of the final determination of the rate.

E. OBRA 93 Limitation. In accordance with OBRA 93, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured. The OBRA 93 Limitation shall be computed using the third prior year desk reviewed cost report trended thru the State Fiscal Year and adjusted for MC+ implementation as defined in Section (18). If the sum of disproportionate share payments exceeds the estimated OBRA 93 limitation, the difference shall be deducted in order as necessary from safety net payment, other disproportionate share lump sum payments, and if necessary, as a reduced per diem.

F. STATUTORY DSH LIMITS. The Balance Budget Act (BBA) of 97 establishes statutory limits for total DSH payments and total DSH payments to institutions for mental diseases (IMD). In accordance with the statutory limits established by BBA of 97 the following methodology will be used to reduce DSH payments if they exceed the statutory limits.

1. The total DSH payments to all hospitals will be reduced by:

   (a) First determining the excess DSH payments by subtracting the statutory DSH limit from the total DSH payments;

   (b) The excess DSH payments will be divided by the total DSH payments to determine the percentage of the excess DSH payments to total DSH payments, and

   (c) The percentage of excess DSH payments will be multiplied by each hospital's total DSH payments to determine the reduction in its DSH payment for each hospital.

2. The total DSH payments to IMD will be reduced using the methodology in VI.F.1.(a), (b), and (c) if the IMD DSH payment exceeds the IMD DSH limit.

XVII. In accordance with state and federal laws regarding reimbursement of inpatient and outpatient hospital services and the implementation of a Medicaid managed care system, reimbursement for state fiscal year 1998 (July 1, 1997 - June 30, 1998) shall be determined as follows.

A. State Fiscal Year 1998 Reimbursement for Inpatient and Outpatient Hospital Services

1. Claims for inpatient and outpatient hospital services for Missouri Medicaid eligible recipients, not enrolled in a Medicaid managed care plan such as MC+, shall continue to be reimbursed in accordance with current regulations and claims processing procedures.

2. Inpatient per diem rates in effect as of June 30, 1997, shall remain in effect until March 31, 1998. Effective April 1, 1998 the inpatient per diem rate shall be rebased using the hospital's 1995 cost reoprt and calculated in accordance with the provisions in section (III) of this regulation.

3. Medicaid Add-on payments based on one hundred percent (100%) of the allocated Medicaid shortfall and ninety-nine percent (99%) of the cost of the uninsured shall be prorated over SFY 98. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive a Medicaid Add-on payment based on one hundred percent (100%) of the allocated Medicaid shortfall and one hundred percent (100%) of the cost of the uninsured.

B. Medicaid Add-Ons

1. Medicaid Add-Ons for Shortfall and Uninsured are based on the estimated inpatient and outpatient cost attributable to Medicaid and the cost of the Uninsured for SFY 98 less the estimated per diem and outpatient reimbursement for SFY 98. The Add-on payments for cost of the Uninsured are not considered in the determination of inpatient recoupments described in section V.D.2.

2. The estimated inpatient cost for SFY 98 is based on the desk reviewed base year cost per day, trended thru SFY 98 in accordance with Subsection III.A, and multiplied by the estimated inpatient days for SFY 98. The estimated outpatient cost is based on the base year outpatient cost trended thru SFY 98. The base year is the third prior fiscal year (i.e., the base year for SFY 98 is the FY 95 cost report). The trending used to approximate SFY 98 costs shall include a utilization adjustment to account for the increased per diem cost resulting from introduction of MC+. The utilization adjustment

shall be phased-out as follows: Year 1 (First full year of MC+) - 100%; Year 2 - 67%; and Year 3 - 33%. If applicable, an initial partial year payment will be made if MC+ is in effect less than a full state fiscal year. The phase-out will then be Year 2 - 100%; Year 3 - 67%; and Year 4 - 33%.

3. The estimated per diem reimbursement for SFY 98 is based on the:

A. June 30, 1997 per deim rate multiplied by the inpatient days, within benefit limitations, estimated to be paid for services provided between July 1, 1997 and March 31, 1998. The estimated outpatient reimbursement for services provided in this period is based on payment at ninety percent (90%) of the base year cost trended through SFY 98, and

B. April 1, 1998 per-diem rate multiplied by the inpatient days, within benefit limitations, estimated to be paid for services provided between April 1, 1998 and June 30, 1998. The estimated outpatinet reimbursement for services provided in this period is based on payment at one hundred percent (100%) of base year cost trended through SFY 1998.

4. An adjustment to recognize the FRA assessment not included in the desk reviewed cost per day is also included. The FRA assessment attributable to Medicaid and Uninsured is determined by multiplying the ratio of base year Medicaid and Uninsured days to total inpatient days by the SFY 98 FRA assessment.

5. An adjustment shall also be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a Medicaid managed care region. The Add-On adjustment shall reimburse the hospital for the prorated Medicaid managed care cost in accordance with the allocation formula described in the Allocation of Medicaid Add-Ons section; and

6. The Add-On payment for the cost of the uninsured is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio from the base year cost report's desk review. The cost of the uninsured is then trended to the current year. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment; and

C. Allocation of Medicaid Add-Ons.

1. Medicaid Add-Ons determined for Medicaid shortfall and cost of the Uninsured shall be allocated based on the estimated effect of implementation of an MC+ except as noted in paragraph XVII.C.3. in accordance with this section. Medicaid per-diem and outpatient payments, which are paid on a claim-specific basis do not require an allocation.

2. Except as noted in paragraph XVII.C.3. Medicaid Add-Ons shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospitals Medicaid population which will remain outside a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual Add-On payment of $100,000, 2) 40% of their Medicaid days are related to Medicaid recipients not eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated Medicaid Add-On is $55,000 [($100,000 25%) + ($100,000 75% 40%)].

3. The Medicaid Add-On shall not be allocated as described in paragraph XVII.C.2., therefore shall include a payment related to MC+ Medicaid the following:

   A. The FRA assessment related to MC+; and
   B. The Utilization Adjustment related to MC+; and
   C. Medicaid Add-Ons related to MC+;
   D. The Utilization adjustment and Medicaid Add-ons related to MC+ adjustment shall be phased-out as follows: Year 1 (First full year of MC+) - $100%; Year 2 - 67%; and Year 3 - 33%. If applicable, an initial partial year payment will be made if MC+ is in effect less than a full state fiscal year. The phase-out will then be Year 2 - 100%; Year 3 - 67%; and Year 4 - 33%.